Medwork Independent Review
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ACCREDITED
INDEPENDENT REVIEW
ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

03/24/2010

MEDWORK INDEPENDENT REVIEW WC DECISION

DATE OF REVIEW: **03/24/2010**

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
10 sessions physical therapy for the cervical spine (97110 & 97530)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed MD Board Certified Orthopaedic Surgeon & Spine Surgeon

REVIEW OUTCOME Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☐ Upheld (Agree)
☒ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Texas Dept of Insurance Assignment to Medwork 03/04/2010
2. Notice of assignment to URA 03/04/2010
3. Confirmation of Receipt of a Request for a Review by an IRO 03/03/2010
4. Company Request for IRO Sections 1-8 undated
5. Request For a Review by an IRO patient request 02/26/2010
6. Republic letter 02/01/2010, 01/18/2010, peer review 02/01/2010
7. FCE 02/02/2010, medical note 02/01/2010, 01/19/2010, 01/18/2010, 01/13/2010, pre-auth 01/13/2010, medical note 01/11/2010, pre-auth 01/11/2010, medical note 01/08/2010, MRI cervical, lumbar, right knee, left knee 01/05/2010, medical note 01/04/2010, eval 12/30/2009, medical note 12/28/2009, treatment plan 12/17/2009, medical note & exam 12/16/2009, medical note 12/14/2009, 12/10/2009, 12/07/2009, 12/02/2009, 12/01/2009, eval 11/30/2009, medical note 11/23/2009, 11/18/2009, 11/16/2009, eval 11/16/2009, medical note 11/16/2009, 11/03/2009, 10/29/2009, OT notes & chart 10/21/2009-10/27/2009

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8. TDI forms 02/25/2010, 02/03/2010, 01/11/2010, 01/18/2010, 12/11/2009, 11/30/2009, 11/11/2009, first injury report xx/xx/xx
9. ODG guidelines were not provided by the URA,

PATIENT CLINICAL HISTORY:

This patient was involved in an accident on xx/xx/xx. The patient sustained injury to the neck and low back. Subsequently, the patient received therapy to the low back. The patient has done reasonably well with that therapy. The patient does continue to have neck pain. Initially there was an issue as to the compensability of the cervical spine. The patient has been recommended to see a neurosurgeon and was assessed on February 1, 2010. It is clear that the patient does have neck symptoms. It was the neurosurgeon's opinion that the patient would benefit from active physical therapy.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

In review of the medical records, the patient fulfills Official Disability Guidelines' criteria for physical therapy to the cervical spine. Previous physical therapy has been directed to the lumbar spine. This patient would benefit from the requested 10 sessions physical therapy for the cervical spine. The previous adverse determination is overturned.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**

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☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**